Touro Infirmary

1401 Foucher Street
New Orleans, LA 70115
Medical Education Demographics Form

Full Name: Sex (circle): Male / Female ☐ ☐	Social Security Number:
Permanent Address: City: State: Zip Code:	**Cell Phone:** Pager: **E-mail:**
Date of Birth: _____	Place of Birth Citizenship (Circle): Native ☐ / Naturalized ☐
Fellows and Residents MD License Number: NPI Number:	ECFMG Required: Yes ☐ / No ☐ (Must be provided upon initial check-in)
Emergency Contact Name:	Emergency Contact Phone Number:

I hereby apply to Touro Infirmary for training as follows:
(Please Print)

Rotation Date: ___/___/___ till ___/___/__	Rotation Type:
(Circle) Fellow ☐ / Resident ☐ / Intern ☐ / Student ☐	Program Type:
PGY Level/Year in School: Length of Program:	Program Affiliation (Circle) LSU / Tulane / Other: ☑

Education and Professional Training:

Medical School:	City/State:	Dates: _____ to _____
Internship Training Hospital/Institution: Type:	City/State:	Dates: _____ to _____
Residency Training Hospital/Institution: Specialty:	City/State:	Dates: _____ to _____
Fellowship Training Hospital/Institution: Specialty:	City/State:	Dates: _____ to _____

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that willfully false representation is sufficient cause for rejection of this application or, if appointed, for dismissal.

Date: _____ Signature:_____

TOURO HOSPITAL SECURITY ACCESS REQUEST and ELECTRONIC AUTHENTICATION AGREEMENT for Enterprise Document Management (EDM)

Please INITIAL each item below. By initialing each item, I agree that I have read, understand, and will comply with this agreement.

_____ I am the only person authorized to use my password(s) and user ID(s).
_____ I will not disclose / share my password(s) or user ID(s) to anyone.
_____ I will not attempt to learn another person's password(s) / user ID(s).
_____ I will not attempt to access information by using a password(s) or user ID(s) other than my own.
_____ I will retrieve or attempt to retrieve from the computer system only medical data that is directly related to the treatment of patients with whom I have a clinical relationship or those patients for whom I have been asked to provide a consultation or for approved educational research purposes. I agree to maintain the confidentiality of all such patient data. I will access patient data only as required by my employment or medical staff responsibilities or for approved educational or research purposes. I agree to access and utilize data on a "need to know basis" in order to perform my job duties.
_____ It is my responsibility to logout of the system. I will not, under any circumstances, leave a computer terminal to which I have logged in unattended.
_____ If I have reason to believe that the confidentiality of any of my password(s)/ user ID(s) has been compromised, I will contact the Health Information Management (Medical Records) Director immediately so that my password(s) / user ID(s) can be deactivated and a new password(s) / user ID(s) assigned to me.
_____ I will immediately report any known or suspected breach of the confidentiality of the system or records/ data obtained from it to the Health Information Management (Medical Records) Director.
_____ I understand that my password(s)/ user ID(s) will be deactivated from the system when I am no longer employed or have privileges at this institution or when my job duties do not require access to the medical record database. I will immediately report any such change to the Health Information Management Director (Medical Records).
_____ I understand my access to EDM will be automatically deactivated after 6 months of non- use.
_____ I understand that medical records confidentiality is required by law, and that there are statutes specifically mandating the confidentiality of, among other areas, mental health, HIV, and drug and alcohol- related treatment records. This includes all HIPPA policies and procedures.
_____ I understand that any fraudulent application, violation of confidentiality or any violation of the above provisions may result in disciplinary action from termination of access to the system and disciplinary measures up to and including termination of my employment or affiliation with Touro Infirmary.
_____ I understand that the Health Information Management Department (Medical Records) maintains an **audit trail of access** to patient information that records the user, date of access, identification of specific patients and account numbers, print activity, and all access to electronic medical records.
_____ I understand that my access rights are subject to periodic review and revision.
_____ I understand that no information that is printed will be released to a 3rd party without following proper release of information policies and procedures. All printed material is confidential and must be disposed of properly in a confidential and secure manner.
_____ I understand that if I do not accept these restrictions of access I may be denied access or have access terminated to relevant computer systems and networks. I understand I will not receive access to EDM until this form is properly completed.

ELECTRONIC / DIGITAL SIGNATURE AGREEMENT

_____ I certify my electronic and/or digitized signature replaces my handwritten signature and will be utilized for medical records as a means of authenticating medical record entries. Electronic signatures are considered legally binding as a means of identifying the author of medical record entries and confirm that the contents are what the author intended.
_____ I am required to review / validate the entry prior to applying my electronic or digitized signature.
_____ I am the only one who has access and can utilize my signature code. Passwords and/or PIN numbers can not be shared.
_____ I understand that my privilege to electronically authenticate medical record entries will be terminated in the event that I misuse it.

I, _____, understand and agree to the above.

Applicant Signature *(First name, Middle Initial, Last Name)*

APPLICANT INFORMATION			
Print Name		**Employee/Physician #**	
Position		**Department**	
Email Address		**Manager Name** (If applicable)	
Network Login		**Phone Number**	
Date			

TOURO MEDICAL RECORD DEPARTMENT OFFICE USE ONLY:

Date Added to EDM:_____ **HIM Staff:**_____ **Security Group:** _____

Date Removed:_____ **HIM Staff:**_____

Date Routed to System Admin. Group: _____ **Routed by HIM Staff:** _____